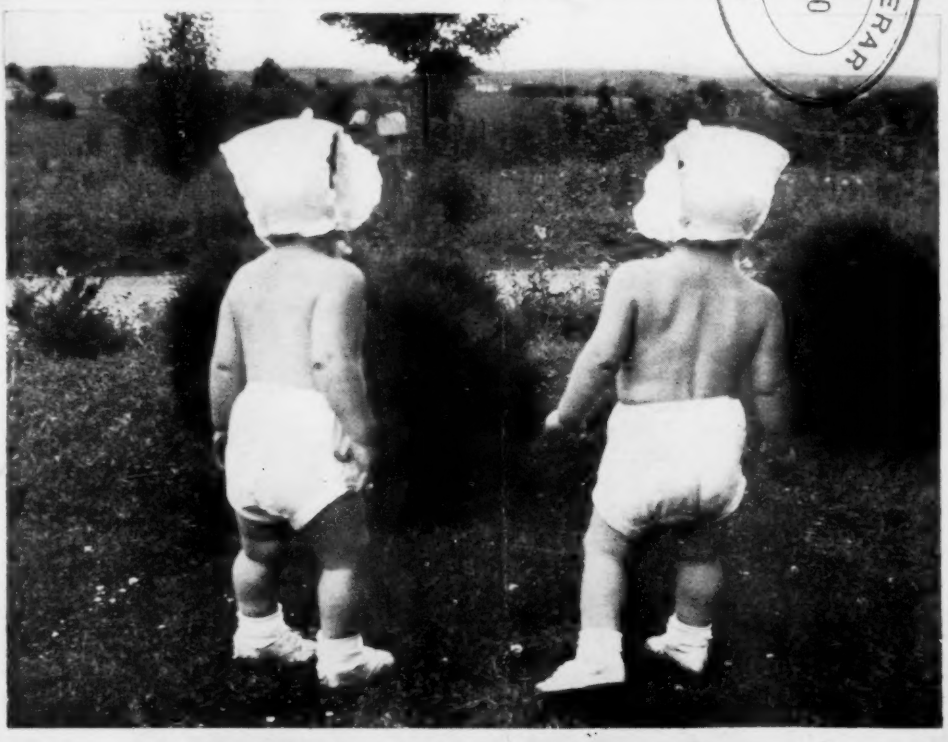
THE CHILD

Monthly News Summary

Volume 4, Numbers 11 and 12 May–June 1940



THESE TWINS HAVE FOUND A HOME

CHILDREN'S BUREAU
U.S. DEPARTMENT OF LABOR – WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

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CHILDREN'S BUREAU

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CONTENTS

THESE TWINS HAVE FOUND A HOME

The twins whose photograph appears on the cover of this issue were left in a river-front rooming house in a South Central State when they were 2 or 3 months old by a man and woman who promised to send money for their care. No money was ever sent, and no trace has ever been found of the man and woman. When the case was reported to the State division of child welfare, the twins were ill and undernourished and had to be kept in a hospital for several weeks. When their physical condition improved, they were placed in a prospective adoptive home under the supervision of the State child-welfare services.

Case-Finding Procedures Developed by the Astoria School Health Study

By George M. Wheatley, M. D.

Department of Health, City of New York; Assistant Director, School Health Study

The administrator of a school health program, whether he serves as a member of the department of health or of the board of education, has the problem of making adaptations to changing concepts of school medical and educational practice. These must be compatible with practical limitations of budget personnel and equipment. For example, the physician's conference with the parent to obtain pediatric history and to give guidance is now generally accepted as a necessary part of the public-school medical examination. The educational concept of individual differences and needs among pupils [1] is now recognized in the public-school curriculum. Recognition of these differing needs is considered an essential function of the teacher.[2]

To determine how concepts such as these can be reconciled with a practical school health program has been a basic purpose of the School Health Study [3] conducted for the past 4 years under the joint sponsorship of the New York City Health Department and the Board of Education.

This paper will be limited to the experience of the School Health Study with four types of procedure used to discover health problems among school children:

1. The medical examination.
2. Teacher-nurse selection of children with suspected problems for the school physician to examine.
3. Screening method, such as the Snellen vision test.
4. Community cooperation illustrated by the dental program.

In developing and utilizing these methods the study has endeavored to apply sound medical and educational theory.

The Medical Examination

If more service is to be rendered to this group of the population, *where* and *how* shall the emphasis be directed? Should it be to achieve the "annual examination" recommended or required by many States? This objective is often repeated by medical, educational, and child-welfare organizations. Or should the effort be to strengthen the work of that "first line of defense," the classroom teacher? It is frequently said that the classroom teacher is the person who knows the most about the child in school. Attention, nevertheless, has long centered on the "routine" examination as

[1] Wrightstone, J. Wayne: Appraisal of Newer Elementary School Practices. Teachers College, Columbia University, New York. 1938.

[2] Joint Committee on Curriculum of the Department of Supervisors and Directors of Instruction of the National Education Association and the Society for Curriculum Study: The Changing Curriculum. Tenth Yearbook of the Department. D. Appleton-Century Co., New York. 1937.

[3] The School Health Study has been maintained by funds from the Liquidating Committee of the American Child Health Association, the Metropolitan Life Insurance Company, the Milbank Memorial Fund, and by social-security funds for maternal and child health through the New York State Department of Health and the United States Children's Bureau. The study, under the direction of Dorothy B. Nyswander, Ph.D., has been located in the Astoria Health District in New York City.

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the accepted method of case-finding. Recently, however, some experienced school health workers have had the courage to question the practice. Rogers [4] states the problem clearly when he says:

> Periodic examinations, whether they come three times in a school lifetime—that is, with an interval of 3 or 4 years, or whether they are made every year, are more or less of an absurdity . . . for diseases and defects do not await the quadrennial, triennial, biennial, or even annual visitation of the school physician. Diseases and defects may appear or become evident within a few days after that visit, and it is manifestly wrong that the diseased or defective child should await [the physician's] return in from 1 to 5 years before his condition is discovered.

Aside from this criticism of the periodic examination as a case-finding procedure is the disclosure of the way the annual examination may be given when this is a legal requirement.

The recent report of the Regents' Inquiry [5] into the school health program states:

> The physical examination afforded school children varied in nature from the very careful, searching pediatric type of examination to one which allowed the passing of children in review before a physician in the most rapid manner possible. The motivating force allowing for examination was almost without exception that of State law. Since it is required that every child have a physical examination each year, the school health and administrative authorities appear, for the most part, to be attempting to meet a legal requirement rather than definitely aiming at improvement of health conditions of their school. . . . Few school systems spend, or are at all likely to spend, enough money to provide a real physical examination every year, and there is no reason why they should do so.

These statements should make the administrator pause to consider if his school examination, when performed as a perfunctory "routine" or "periodic" or "annual" examination, may not be a relatively inefficient and costly procedure. There is only one kind of examination a competent physician should be expected to give to children. Whether it be in a private office, in a clinic, or in a school medical room, the medical examination should be a careful, well-planned procedure, which includes an interview with the parent for the purpose of obtaining a pediatric history, planning for care, and an explanation of the medical findings. The physical examination should be as thorough as the circumstances and facilities permit. The cursory 5-minute examination of young children without the parent present is not good pediatric practice, nor is it good education to permit children and parents to believe that the school approves this kind of examination.

The Astoria School Health Study has made the routine examination a more thorough type of procedure. It recognizes that the school physician has an important part to play, both in case-finding and in health education. The first step in improving the examination was to give the physician the opportunity to do a sound professional and educational job. The "routine" was eliminated from his examination. It appeared that endless search for children with defects through routine examination of masses of elementary school children dulled the physician's diagnostic acumen. Why not cultivate his professional skill and sharpen his interest in his work through consultation cases?

In order to reduce theoretical considerations to practical reality, three broad questions were applied to the routine examination procedure:

1. Are there some parts of the school examination now being carried out by the physician which someone else is equally well, or better, qualified to do? Should the physician do vision tests and height and weight measurements? Is the school physician the best person to discover dental caries? Is the whispered voice reliable in the discovery of hearing defects? Is the routine examination of the lungs in elementary school children a productive procedure?

2. Are the special abilities of the physician utilized to the best advantage? Should his professional experience and influence be added to the nurse's at the time of the examination to work out a plan with the parent for care of the child presenting a health problem? Should the physician give more attention to history-taking from the parent to evaluate physical function? Should he be allowed the opportunity to interpret his findings to the parent, teacher, and nurse? Should the school physician, when complications arise over diagnosis and recommendation, have the opportunity to make professional contacts with private physicians?

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[4] Rogers, J. F., M. D., Dr. P. H.: Frequency of Periodic Health Examinations. *Journal of School Health*, Vol. 10, No. 1 (January 1940).

[5] Winslow, C.-E. A: The School Health Program. Regents' Inquiry, McGraw-Hill Book Co., New York. 1938.

3. Is the physician rendering his professional services where they are most effective? Rather than utilize the bulk of his time for "routine" examinations, would it be a more effective use of his limited services if he were to examine children with suspected problems selected for him by teacher and nurse? Is it an effective use of his time to examine children periodically in order to learn if their defects have been corrected?

It is not possible in the limits of this paper to give the answers to all the questions raised.[6] A general description will be given of the school examination, which was based on our answers to these questions.

The examination by the physician is made the focal point of the health service. When the physician examines the child all information that it is possible to get is assembled. The teacher, the nurse, and the parent all contribute data, either as history, reports, or tests. More time is given by the physician to the interview with the parent than to the physical examination of the child. The objectives of the conference with the parent are:

1. To study the child's development, his family, his illnesses, and his present health and living habits;
2. To correlate this knowledge of the child's day-to-day functioning with the physical findings;
3. To plan for treatment of the problems identified through the interview and physical examination;
4. To give guidance and health information to parents of normal children. The interview with the parent of the well child is an opportunity to give health information and to advise preventive measures for other members of the family. Preschool children need vaccination and protection from diphtheria. A chronic cough in an adult may need further investigation.

Physical findings are classed as defects and action urged upon the parent only if they can be correlated with the child's health history. In this way, for example, a history of sore throat, middle-ear infection, or swollen glands carries more weight than the appearance of the tonsils, both in diagnosing a tonsil defect and in urging treatment. Nutrition is not estimated by reliance upon height and weight at the time of the examination but is evaluated in terms of physical appearance, pediatric history, which includes eating and sleeping habits, and weight and height increments. This principle is applied to other conditions throughout the examination.

By the emphasis on history it is common to uncover conditions that, without it, would never have been disclosed in the routine physical examination with the child stripped to the waist. Diabetes, family history of tuberculosis, behavior problems, nephritis, pyelitis, are illustrations.

Occasionally, because of the confidence established with the parent, an even more thorough physical examination can be carired out. Recently through this type of conference and examination a case of pseudohermaphroditism was discovered. The parent wanted the physician's advice. It was possible to discover that the child raised as a girl was sexually a boy. A plan was worked out with the parent to help adjust this extremely complicated medical and social problem.

To keep the interview and examination within an average of 15 minutes it is necessary to eliminate some parts and revise the procedure of the examination. The testing of vision[7] and hearing[8] by the physician is eliminated; the nurse does not spend time weighing and measuring children at the time of the examination—this is done by the teacher; the routine lung examination by auscultation is not done; interruptions of the physician are reduced to a minimum by more careful planning; the nurse takes down on the medical record the notes dictated by the physician as he conducts the interview with the mother and examines the child. This brings the nurse into active participation and understanding of the medical findings. Follow-up examinations by the physician, to determine if dental and visual defects have been corrected or diseased tonsils removed, are discontinued. These are handled by the nurse on presentation of certificates from the dentist and physician who have given

[6] A comprehensive report of the 4-year operation of the study by the School Health Study Committee, Philip Van Ingen, M. D., chairman, is now in preparation.

[7] This was done by teacher and nurse.

[8] This was done by an audiometer survey made by Board of Education through the Works Progress Administration in the spring term of 1938.

the necessary treatment. Routine examinations in the eighth grade are eliminated in favor of "consultation" on "problem" cases, selected from all grades in the school by the teachers and the nurse.

By eliminating all procedures that did not stand the acid test of critical analysis and by transferring other duties to teacher and nurse the physician is able to render a real professional service within a practical limit of time. He does 8 to 10 examinations per 3-hour session (other services rendered by the physician during this 3-hour session may include inspections and toxoid injections).

To compensate for reduction in the number of children who receive the school medical examination procedures have been developed which permit children to be seen briefly by the physician to decide on the need for the medical examination. This is called inspection by the physician. Children are referred for inspection by teachers and nurse because of signs and symptoms or information about the child suggestive of a health problem.

In summary, the school-examination procedure developed in the Astoria study, and now being introduced in the elementary schools throughout the city, has these three objectives:

1. To make careful selection of children on the basis of health history contributed by parent, teacher, and nurse and the examination by the school physician;
2. To make thoughtful referral based on a plan for care worked out by the physician with parent and nurse in the light of facilities for treatment;
3. To give educational guidance to parents on the child's health problems and living habits.

This examination service, because of limited staff, can be given only to children newly admitted to the elementary school system and to children selected after review by nurse and physician as consultation cases.

Teacher-Nurse Selection of Children

The Astoria School Health Study has placed the greatest emphasis on case-finding in the classroom. The day-to-day observation of the classroom teacher in the elementary school and her knowledge of her pupils is potentially the best means of discovering children who may need medical attention. This has been repeatedly stated and recently emphasized by Wilson and Clancy.[9]

To furnish the teacher with a tool to assist her in her observations, a pupil-health record was developed. In addition to space for recording vision scores and weight measurements, this card provides for notations by the teacher of any signs of abnormal health or behavior. Furthermore, there is space for explanation of the medical findings, for recommendations on classroom management of the pupil, and for follow-up reports by the physician and nurse based on the school examination. Because the record passes on with the pupil to the child's next grade, subsequent teachers can profit and be guided by the notes and reports. The teacher now has a tangible means of promoting her interest in the health of each pupil.[10]

The health service starts in the classroom. The school nurse makes a classroom visit to each teacher during the term to review the health status of each child and to guide the teacher in the use of the health record. Through this visit children whose signs and symptoms may not have been considered significant by the teacher may be brought to medical attention. The physician is available when he visits the school to render consultation service on these children who have been selected by the teacher and nurse. The problems which are usually selected through this periodic inventory visit by the nurse are children with chronic illness; children who are absent frequently without satisfactory explanation; children not gaining weight; children who have previously been doing well in school and have suddenly begun to fail; children previously alert and active, now tiring easily. Some of the children selected may be known to the teacher and nurse through history of fre-

[9] Wilson, Charles C., M. D., and Helen M. Clancy, R. N.: Trends in School Health Examinations. *Public Health Nursing*, Vol. 31, No. 4 (April 1939), p. 219.

[10] Fegley, Marian V., R. N.: Modern Tools for School Health. *Public Health Nursing*, Vol. 31, No. 9 (September 1939).

quent sore throats or ear discharge, or because of behavior problems in the classroom, or because of frequency of urination. These are problems familiar to all classroom teachers. The nurse and physician are interested in such cases. When these children are seen by the school physician, depending on his judgment, he may select the child for the complete history and physical examination, with the parent present, or may render an opinion that will dispose of the problem, either as no case or as a case for further teacher and nurse observation.

This kind of health service has not only put the medical service on a more rational basis comparable to health service in the community but has reached more children who need medical attention. A further advantage of this type of service is that it brings the school physician into closer contact with the classroom teacher and her problems. Not only is this a more satisfying kind of service to render with a limited staff, but, from a statistical standpoint alone, the teacher-nurse selection of cases is more profitable as a case-finding method than is routine examination.

An analysis of the records of children receiving the routine examination as entering pupils, of children examined as specially referred cases, and of children examined by classes (table 1), shows that 80 percent of the children examined as specially referred cases had physical defects, contrasted with 44 percent of the children in the entering group; only 28 percent in the group receiving the routine examination as given to every child in the fifth, sixth, or seventh grade without the parent present were found to have physical defects.

From the point of view of economy of effort in the discovery of health problems, it appears that efforts should be directed toward improving the ability of the teacher to recognize children who may need medical attention. Moreover, the utilization of the physician as a final step in the process of selection, except in obvious emergencies of acute illness, means that a considered medical opinion can be rendered. This type of service furthermore gives a more even distribution of medical attention throughout the school.

TABLE 1.—*Frequency of defects found when all children in class were examined and when children were specially referred for examination during the first half of the school year 1938–39*

Finding of defects	All children in class examined				Children specially referred for examination in grades 2 to 9, inclusive	
	On entering kindergarten and grade 1 [1]		In grades 5, 6, and 7			
	Number	Percent	Number	Percent	Number	Percent
Total children examined	426	100	689	100	241	100
Defects found [2]	188	44	191	28	194	80
No defects found	238	56	498	72	47	20

[1] Children examined by private physicians and children examined during the summer are not included.

[2] Children with visual or dental defects only are not placed in the category of children with defects in either of above groups. Dental and visual defects were picked up by special programs which included all children in the schools.

Table 2 shows the spread of doctor-nurse service throughout the grades of the schools in which the experiment was carried on during the first half of the school year 1938–39. It will be seen

TABLE 2.—*Children enrolled and children receiving attention from doctor or nurse in each grade during the first half of the school year 1938–39*

Grade	Children enrolled	Children receiving attention [1]	
		Number	Percent of total enrolled
Total	7,950	[2] 3,888	49.0
Kindergarten	374	204	54.5
First grade	834	494	59.1
Second grade	800	325	40.6
Third grade	832	372	44.8
Fourth grade	799	258	32.4
Fifth grade	853	424	50.0
Sixth grade	880	424	48.0
Seventh grade	874	492	56.3
Eighth grade	755	372	49.4
Ninth grade	343	206	60.0
Rapid	271	160	59.2
Special	335	157	47.0

[1] Excludes children receiving only notation for morning inspection.

[2] Includes 2,417 children (62 percent) who received attention only from the nurse and 1,471 (38 percent) who received attention from both doctor and nurse.

that, with the exception of the second, third, and fourth grades, nearly half of the children in each grade received some attention from the doctor or nurse.

An additional value of the teacher-nurse-doctor selective process is the history which is developed for each child who is to be seen by the physician. This is a marked advantage in enabling the physician to arrive at a diagnosis.

Vision-Screening Program

At the beginning of the Astoria School Health Study it was found through analysis of the medical records that the vision-screening program and follow-up of children with visual defects was not on a particularly sound basis.

It is customary in New York City for the classroom teacher to use the Snellen test for each pupil each term. About 250,000 children (32 percent of the approximately 770,000 children in the public elementary schools) were tested by physicians and nurses each year. There seemed to be little or no coordination between these two separate services for the discovery of visual defects. Teachers sent notices to the parent advising care. This was often done independently of the notice that the nurse might send home regarding the same child. In many instances it was found that children with visual defects discovered by the teacher and not reported to the nurse had received follow-up work only by the teacher, and because of the periodic shift of children from teacher to teacher many visual defects remained uncared for.

Problems Demanding Solution.

The Astoria School Health Study, in developing an experimental vision-screening program, used the following as a guide:

1. Responsibility for the selection and follow-up of vision cases had to be allocated.
2. The reliability of the teacher's selection of children with visual defects had to be determined.
3. Follow-up procedures for the nurse, which would be effective and continuous, had to be instituted.

Allocating Responsibility.

With regard to the first problem the teachers were given the responsibility for screening the vision of all school children from the second grade on. The teachers each term submitted to the nurse the names of children having visual acuity of 20/40 or less and no glasses. The nurses retested all these children.

Children with visual acuity of 20/40 or less who already own glasses having the best possible correction at the time are advised to go back for periodic reexaminations to the person who prescribed the glasses.

Reliability of Teacher Referrals.

Visual acuity of 20/50 or less.—The nurses found that the reporting of visual acuity of 20/50 or less by the teacher was reliable. This conclusion was reached by retesting under standard conditions all the cases reported by the teacher. The nurse's results agreed with the teacher's selection in nearly 100 percent of the cases. When reports from oculists, optometrists, and so forth were tabulated, it was found that acuities of 20/50 or less reported by the teacher were substantiated in 95 cases out of 100.

Visual acuity of 20/40.—On the other hand, acuities of 20/40, on retest by the nurse, were found to be reliable in only 40 cases out of 100. When the children who, on retest by the nurse, were found to have visual acuities of 20/40 were examined by oculists and optometrists, the nurse's findings were substantiated in 95 percent of the cases.

Nurse's Procedure for Follow-up.

Analysis of the nurse's retest results and reports from the oculists led to the establishment of definite procedures. Teachers continue to test the vision of all the children, but each term they submit two lists of names to the school nurse. One list contains the names of children having a visual acuity of 20/50 or less and no glasses. The second list contains the names of children having a visual acuity of 20/40 and no glasses.

Visual acuity of 20/50 or less.—On receipt of these two lists the nurse begins her follow-up work. The children with an acuity of 20/50 or less receive immediate attention. The nurse *without retesting* invites the parent to visit the

school to consult with her about the child's vision. If a parent fails to respond to the nurse's invitation, a home visit is made.

Visual acuity of 20/40.—The nurse retests all children referred by teachers as having a visual acuity of 20/40. The nurse invites the parents in for a conference and urges care for all children retesting 20/40 or less.

Where formerly there existed divided responsibility, duplication of effort, and neglected cases, teachers and nurses now have definite responsibilities. The reliability of teachers in the selection of cases has been determined, and nurses have definite procedures for the follow-up of vision cases.

A study of the following data demonstrates what can be accomplished in a vision program when the work of teachers and nurses is integrated.

The following tabulation shows the number of children who were referred by the teacher to the nurse for retesting and also the total number of cases which the nurse had to follow up during the first half of the school year 1938–39:

Results of vision tests	*Number of children*	*Percent distribution*
Total children tested	6,889	100.0
Acuity 20/40 or less on original test (referred by teachers)	443	6.4
Followed up by nurse	308	4.4
Retested (original test, acuity 20/40)	93	1.3
Not retested (original test, acuity 20/50 or less)	215	3.1
Not followed up by nurse (retest, acuity more than 20/40)	135	2.0
Acuity more than 20/40 on original test with or without glasses (includes children not referred by teachers and children with this acuity who were referred because of symptoms of strain)	6,446	93.6

Of the 308 cases followed up by the nurse, in 272 cases she held parent consultations in school. Thirty-six parents failed to respond. The nurse, therefore, made home visits in these cases. The results of the nurse's follow-up work during the first half of the school year 1938–39 were as follows:

Results of follow-up work	*Children followed up*	
	Number	*Percent distribution*
Total children followed up	308	100.0
Glasses obtained	124	40.3
Correction in process	142	46.0
Glasses not needed	19	6.2
No action by parent	23	7.5

Table 3 shows the progressive decrease in the number of new cases in the schools included in the study since the introduction of this coordinated program.

TABLE 3.—*Reference by teacher on basis of original test and follow-up by nurse of children receiving vision tests in 4 successive half school years.*

Results of vision test	Percent distribution			
	Second half, 1937–38 (7,459 children)	First half, 1938–39 (6,889 children)	Second half, 1938–39 (6,810 children)	First half, 1939–40 (6,746 children)
Total	100.0	100.0	100.0	100.0
Acuity 20/40 or less (referred by teacher)	10.8	6.4	5.1	3.7
Followed up by nurse	8.5	4.4	3.7	2.9
Not followed up by nurse [1]	2.3	2.0	1.4	.6
Acuity 20/40 or more with or without glasses [2]	89.2	93.6	94.9	96.3

[1] Acuity of more than 20/40 on retest by nurse.
[2] Includes all children not referred by teacher and children with this acuity who were referred because of symptoms of strain.

From the figures for the latest period of the demonstration it would seem that a large proportion of the children needing glasses have received them, that bedrock has been reached in both cases reported by the teacher and those followed up by the nurse, and that only new cases which develop from term to term are now being selected. This plan for managing the vision program was introduced throughout the city of New York beginning September 1939.

Community Cooperation for Dental Care

The Astoria School Health Study assumed that the problem of dental caries is not solved

through setting up machinery to discover this defect but should be approached through a program which places all children in the hands of dentists periodically.

Three basic ideas govern the operation of the dental program:[11]

1. Dental disease can be controlled through continuous dental care.
2. Education of parents and cooperation of the dental profession offer a solution.
3. Teachers are in a strategic position to aid the program.

The efforts of three key individuals were coordinated in the dental program—the teacher, the parent, and the private dentist.

The teacher took the initiative through a letter given to each child to point out the facts on dental-health methods, hygiene, and the importance of dental care. This letter awakened the parents' concern and responsibility for the problem by pointing out educational facts about teeth. Dentists were brought into active participation in the program through the representatives of the dental societies in the community. Meetings were held with the dentists, and the plan of procedure was outlined. The dentists pledged cooperation in the examination of all children referred to them. In the dentist's office children were examined with the parents present. This gave the dentist the opportunity of pointing out the need for treatment to the parent. It was also an occasion for the parent to learn the importance of continuous care of the teeth. In the school the teacher interviewed each child to determine the status of care during the course of the year. The teacher based her follow-up of the individual case on the parent's response. The child's progress and status were recorded on the pupil-health card by the teacher.

In the first year of the cooperative dental program 5,664 (88 percent) of the 6,436 children in the 8 schools in which this program was conducted were examined by dentists, with the following results:

Results of dental program	*Children examined*	
	Number	*Percent distribution*
Total children examined	5,664	100
Treatment needed	4,580	81
Treatment completed at end of school year	1,568	28
Under treatment at end of school year	1,568	28
No treatment received	1,084	19
Treatment not needed	1,084	19

Of the 5,664 children examined by dentists, 68 percent were examined by private dentists and 32 percent by clinic dentists.

Summary

Although this paper is limited to a report of case-finding methods for school health service, it should not be thought that we are interested only in the child with defects. No attempt has been made to indicate the experimental work done in staff education or in developing procedures for physicians and nurses to give guidance to all children.

The Astoria School Health Study has endeavored to work out a practical service which incorporates the best concepts of pediatrics and education. The type of examination that the school physician gives in the school is a pediatric examination in which the conference with the parent and the medical history of the child are essential parts. Because of limited staff this type of examination has been given only to entering children and to children selected through a process of screening by teacher, nurse, and physician. This kind of medical examination, from the experience of the School Health Study, assures sounder selection of cases and better appreciation by the parent of the need for treatment.

The plan for treatment is equally important with the discovery of the health problem. Lines of communication have been established among both private and public medical and

[11] A complete report of this dental program was made by S. S. Lifson of the School Health Study staff at the October 1939 meeting of the American Public Health Association in a paper entitled "How the Community Dentist Can Participate in the School Dental Program."

social resources in the community. School physicians and school nurses are on working terms with private physicians as well as social workers. This rapport has led to assistance for the child whose physical and mental condition may be attributed to his family's social or economic need. It has led also to better understanding by the community agencies of the objectives of the school health service.

More attention should be centered on improving the ability of the teacher and nurse to select children for the physician. This appears to be a practical means of spreading service and of selecting children physically below par. The pupil-health card has been found to be a useful tool for centering the teacher's interest on her pupils' health.

For defects of vision and hearing, the correction of which is so vital to the educational process, it seems more practical to put the emphasis on developing testing procedures, such as the audiometer test for hearing and the Snellen test for vision. The teachers' tests were found to be reliable for the group of children having a visual acuity of 20/50 or less, who are not retested by the nurse. Only children with an acuity of 20/40 are retested. Coordination of the teacher's and nurse's efforts in the selection and follow-up of children with visual defects resulted in better selection and correction of visual defects.

Statistical data are presented to show the result of cooperation between the school and the community dentists in the dental care of school children.

These are all methods that the resourceful administrator may be able to apply to his own situation.

Special Care for Premature Infants in Rural Homes[1]

By Robert C. Hume, M. D.

Assistant Commissioner, Cattaraugus County Department of Health, Olean, N. Y.[2]

In attacking the problem of reducing infant mortality the medical profession has found that premature birth is an important factor. A study made during a recent year by the New York State Department of Health[3] has shown that 4.3 percent of the infants born alive were premature and that 39 percent of the prematurely born infants died in the first month of life.

In some States, notably Massachusetts, the department of public health has approached the problem of improving care of premature infants with the idea of hospitalization for all babies weighing less than 5½ pounds at birth.

Though this is theoretically an ideal plan it was not entirely suitable to a rural area such as Cattaraugus County, whose population of 73,000, scattered over 1,343 square miles, is served by four general hospitals without separate nurseries for premature infants. Forty percent of the 1,400 births each year in this area are home deliveries, chiefly because of geographic isolation and financial inability on the part of these families to meet hospital expenses.

It has been stated in pediatric textbooks for more than 30 years that the three chief needs of prematurely born infants are maintenance of body temperature, proper feeding, and protection from infection, yet these needs had not generally been met in rural areas. The farmers' families in Cattaraugus County cannot, in many cases, afford even ordinary hospital care. Furthermore, premature babies frequently arrive unexpectedly. Families need help for premature babies in their homes.

[1] This article appeared in substantially the same form in *Canadian Welfare Summary*, Vol. 15, No. 3 (August–September 1939).

[2] The author joined the New York State Department of Health on March 16, 1940, as assistant district State health officer.

[3] Yerushalmy, J.: Neonatal Mortality by Order of Birth and of Age of Parents. *American Journal of Hygiene*, Vol. 28, No. 2 (September 1938), pp. 244–270.

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Therefore, a local program to meet the need of the premature baby was started about 2½ years ago.

In general this program for the care of premature infants in a rural area consisted of:

1. Instruction of the public-health-nursing staff as to the needs of premature infants and methods of meeting these requirements.
2. Provision of portable incubators or heated beds for home use.
3. Informing the medical profession of the county regarding the need for care of premature infants and the equipment available.
4. General publicity.

Staff Education

The provision of proper nursing is probably the most essential part of any program for reducing infant mortality due to prematurity. To make this available the county department of health sent its supervising nurse to Boston for the 2-week training course in nursing care of premature infants at the Boston Lying-In Hospital.[4] Here she was able to observe and practice the newest approved methods of hospital care for premature infants. On her return she was able to adapt these newer techniques for use in homes and to instruct the staff nurses of the department in these special nursing procedures.

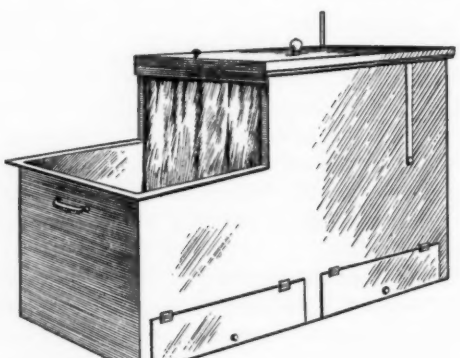
The department's consultant in maternal and child hygiene, from the county medical society, visited the Sarah Morris Station in Chicago, learning from Dr. Hess the special techniques used there. He has discussed these methods before the practicing physicians and now serves as a local consultant for special problems concerning premature infants.

Portable Incubators

Our first portable incubator was a metal-hooded crib, obtained from Dr. Hess in Chicago. It was heated by an electric bulb. This model was soon modified by the addition of an inexpensive thermostat, such as is used in chicken incubators, and several of these were made of sheet metal by a local metalworking plant. Later, further modifications were made, and a more efficient unit was designed, with the heating element beneath the mattress and a more easily adjusted, precalibrated thermostat. For homes without electricity the bed was equipped with metal flaps allowing the placing of heated bricks, stones, or flatirons beneath it.

The county department of health now has 14 of these portable incubators distributed throughout the county in district health stations, where they are quickly available on request of local physicians. These incubators effectively maintain a uniform environmental temperature around the baby. Of almost greater importance is the fact that this device is a consistent reminder to the family of the special need of small infants for good nursing care and protection from infection.

The most recent and useful incubator is 29 inches long, 16 inches wide, and 20 inches high, is constructed of sheet metal, and weighs about 40 pounds. The baby rests on an insulated tray above the 150-watt heating element regulated by a thermostat, which can be adjusted from the outside to maintain any temperature from 70° to 100° Fahrenheit. The baby breathes the air of the room. The question of increasing humidity, a factor stressed in some large hospitals, has not concerned us greatly, for in many country homes where wood fires are used the problem has not been so acute as it would be in steam-heated city apartments. When the incubator is heated with bricks or flatirons there is, of course, no automatic feature available and additional attention is required. A



[4] Through the courtesy of the Massachusetts Department of Health.

separate heating unit utilizing a small alcohol lamp for heating water, which circulates automatically through copper coils beneath the mattress, has recently been developed. This will run for 10 to 12 hours without attention and should facilitate maintenance of uniform incubator temperature in homes without electricity.

In other parts of New York State incubators have been made of plywood by National Youth Administration workers. The cost of our metal unit has varied from $25 to $60. From early experience we learned that the cheaper thermostats without calibration caused some dissatisfaction because of difficult adjustment. We now use a more reliable thermostat in which calibration from 70° to 100° Fahrenheit is visible from the outside.

Education of the Medical Profession

Simply providing incubators did not solve our problem. It was essential that the local practicing physicians who attend the births and care for the premature infants be informed as to the special care required for small babies. For this purpose an institute on care of premature infants was organized early in the program. All physicians in Cattaraugus County and those in adjoining counties who practice in the county were invited to an evening meeting sponsored by the Cattaraugus County Medical Society, at St. Francis Hospital, Olean. Dr. B. B. Breese, a pediatrician from Strong Memorial Hospital in Rochester, who had conducted a special study of premature infants, was invited to address the physicians. At this session mimeographed material was distributed, including an outline of special requirements of small babies and also the hospital routines used at the Sarah Morris Station for premature infants in Chicago and at the Boston Lying-In Hospital. The supervising public-health nurse demonstrated to the physicians the use of incubators, premature jackets, gavage feeding tubes, oxygen-administration apparatus for infants, and various types of suction apparatus. To make sure that these newer techniques could be applied when ordered by the physician, an afternoon session for nurses caring for newborn infants was also provided. At this meeting special nursing procedures were demonstrated and discussed in detail before a group of about 60 nurses and hospital administrators in the county.

General Publicity

In addition to informing the doctors and nurses of what they might do it seemed wise to interest the public in the problem of premature infants. For this purpose exhibits at two successive county fairs were designed to bring the problem of saving premature babies to the attention of the public. Newspaper articles were printed, with photographs of incubators in use for local babies. Repeated reference to this program was made at meetings of the Cattaraugus County Council of Maternal and Child Health. A short motion picture produced by the department, which shows these incubators in use in homes, has helped to interest local groups in the problem of providing special care for premature infants. These steps have spread knowledge of this program to a large proportion of the population. Now most families welcome an incubator when needed in the home, not only for the uniform environmental temperature which it provides for the baby, but as a symbol of the special need of their small baby for careful feeding, good nursing care, and protection from infection.

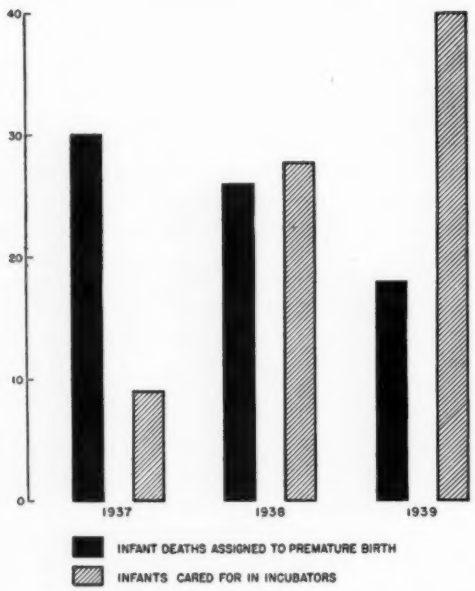
Results

Incubators supplied by the Cattaraugus County Department of Health in the past 2½ years have been used in rural and urban homes, in maternity homes, and in each of the hospitals. Calls from hospitals still come to us for additional units when several small babies are being cared for at one time. So far we have been able to supply an incubator within a few hours to each physician requesting one for home use. The baby is kept in the incubator from 2 weeks to 5 months, according to the physician's orders and the baby's condition.

In several instances babies born prematurely at home have been placed in an incubator and, with this protection, transported to a hospital

by automobile. The baby usually remains in the same incubator while at the hospital and if necessary after his discharge to the home.

NUMBER OF INFANT DEATHS ASSIGNED TO PREMATURE BIRTH AND NUMBER OF INFANTS CARED FOR IN INCUBATORS, 1937-39



With the increasing realization by physicians and the public of the facilities available more calls come to us for incubators to be sent to private homes when premature infants born in hospitals are discharged. This gives the public-health nurse an early opportunity to instruct the mother in the special care of the small baby when she goes to the home with the incubator requested by the family physician. The closer the cooperation between the hospital and the public-health nurse the better, in this as in other matters.

It is difficult to measure the results of a program such as this, but the number of infant deaths certified as due to premature birth has decreased in the years in which our work has been developing. In 1937, 30 deaths were reported as due to premature birth; in 1938, 26; in 1939, 18. We believe that this decrease in deaths was directly due to the better care received by premature infants. The number of babies who were cared for in incubators in 1937 was 9; in 1938, 28; in 1939, 40. The 1939 figure includes 10 infants who were cared for in new hospital incubators. The study demonstrates that a health department can stimulate its community to save premature infants.

It is realized that home care of premature infants is in no way superior to hospital care, but where the latter is not available a small amount of relatively inexpensive equipment, supplemented by special nursing care, has made it possible to improve the chances for life of small infants born at home.

Methods of Teaching Prevention of Diarrhea in New Mexico

By Hester B. Curtis, M. D.

Director, Division of Maternal and Child Health, New Mexico State Department of Public Health

New Mexico has the highest infant death rate in the United States. More than 40 percent of our infant deaths occur without medical attendant. No one knows how many of these might have been prevented if a physician could have been in attendance. We live in a large, sparsely populated State, and the doctors are concentrated in the towns.

For a long time the State Department of Public Health speculated regarding the probable cause of these unattended deaths. We thought it likely that they followed the general pattern of deaths from specific causes where the diarrheal diseases have a prominent place. When our statistician charted the infant deaths from known and unknown causes for 3 years by the month in which they occurred, we had some evidence in support of our theory that very many of these deaths are due to the diarrheal diseases, inasmuch as the curve begins to rise in May,

reaches its peak in August, and drops again in October.

We believed it probable that flies play an important role in the dissemination of diarrhea. An experiment in sanitation has confirmed this impression. Atrisco is a fairly isolated village of 150 families. In the summer of 1937 the United States Public Health Service survey of dysentery in New Mexico found 28 cases of dysentery in the village and many carriers of the organisms causing this disease. There were 2 infant deaths during this epidemic.

Between that summer and the next, the Works Progress Administration Community Sanitation Project installed a sanitary pit privy for every family in Atrisco. Each family was instructed in the proper use and care of the privy. That the instruction is being put into practice is shown by the fact that the doors of the privies are kept shut and not left carelessly swinging open. The summer following the installation of the privies there were two cases of diarrhea in adults who had been to Albuquerque and whose history indicated that they had probably contracted the disease there. There were no other cases, and the number of carriers decreased.

Improved sanitation coupled with education of the people in the proper use of facilities seems to be the answer to the diarrhea problem in New Mexico.

Although much progress has been made by the Works Progress Administration Community Sanitation Project, there are still literally thousands of insanitary privies in the State. Thousands of families have no facilities at all. This situation will probably continue for a long time, since the cost of material for the building of a privy is approximately $20, a price which many of the people cannot afford. We recommend the installation of pit privies when it seems feasible, but emphasis is constantly laid on cleanliness and the elimination of flies from the environment.

The State Department of Public Health has two good motion-picture films on the fly as a carrier of disease, useful for group meetings in the larger communities where electricity is available. A recently acquired truck equipped with sound-film apparatus will make it possible to show the films to people in the smaller communities.

The local health department medical conferences for well babies teach the prevention of diarrhea through the doctor's guidance of the mother in feeding her baby; through his instructions regarding cleanliness; through his example in washing his hands before touching her baby; through the display of practical exhibit material and the distribution of appropriate literature.

All the public-health nurses on the staff of the State Department of Public Health visit mothers in their own homes. They appraise the home situation and suggest practical ways in which the mother can protect her family, especially the baby, in the everyday care she gives. Elimination of conditions that attract flies and of breeding places is urged. If it is not possible to screen the doors and windows, then the baby's bed (which may be made out of a cardboard carton) can be covered with an old veil, lace curtain, or piece of mosquito netting. The mother is shown how to dispose of excreta and garbage. If she uses wood for fuel, the ashes make a good substitute for chloride of lime to use in the privy. The laundering of the baby's diapers is carefully demonstrated. A lard bucket may have to take the place of the sanitary enamel pail for holding soiled diapers. When water is scarce, as it often is, it is suggested that the mother scald out the bucket with the hot water used to rinse the diapers.

Much effort is put into encouraging the mother to nurse her baby. In some communities, where the mother does not have a clock, it has been possible to help her keep a regular schedule, which is important in maintaining the supply of breast milk, by using the church and school bells as time pieces. Boiling utensils used in feeding the baby or giving him water is demonstrated, together with their storage in a place protected from flies. In case the mother takes the baby out and must carry his milk or drinking water in a bottle she is taught to cover the nipple with a piece of white cloth which has been boiled. She is urged to take boiled water with her whenever the baby is to

be away from home even for a few hours; otherwise the temptation to allay his thirst with unboiled water may prove too great.

The washing of hands is demonstrated over and over again. Our nurses have discovered that the "pour method" of hand washing is not only the cleanest but also the most economical of water. A few of the nurses have shown mothers how to make fly traps or very inexpensive sticky fly paper (ingredients: castor oil and resin—a good use at last for castor oil!).

In some situations it is possible for the nurses to teach groups of mothers. In one county where there are several nurses a number of consecutive lessons on the prevention of diarrhea were given at the well-baby medical conferences last summer according to the following outline:

What is diarrhea?
How is diarrhea carried from one person to another?
How can we keep babies from having diarrhea?
What shall we do if diarrhea develops?

Posters made of pictures cut from magazines and bearing a message in Spanish or English stamped in large type were used as visual aids. The doctors conducting the conferences were invited to give brief talks to the mothers. Then the public-health nurse in charge encouraged the mothers to ask and answer questions and to tell what they themselves were doing to prevent diarrhea in their children.

A series of lessons in mothercraft is occasionally given by public-health nurses to groups of 'teen-age girls. The prevention of diarrhea has, of course, an important place in these lessons.

In some schools the public-health nurses have meetings with older pupils in the classroom. One of the subjects which they discuss is how boys and girls can help to protect their homes from flies.

Many rural schools in New Mexico have become interested in providing better toilet and hand-washing facilities for the children. A number of schools have obtained screened cabinets for storing the lunches brought to school. Teachers are helping the children to make the right use of these facilities and are teaching them the reasons why this is important.

The Farm Security Administration is cooperating in a practical way. They include in the plans for their clients the improvement of homes by the screening of doors and windows and the erection of sanitary privies. They sometimes call their clients together and invite the district sanitarians to talk about fly elimination.

There is no test by which we can measure the effectiveness of these various efforts to teach the prevention of diarrhea, but we are encouraged by the fact that our infant death rate is gradually coming down.

Clinic Service for Crippled Children

The Medical Social Worker in a State Crippled Children's Program

By Georgia Ball

Medical Social Consultant, Crippled Children's Division, U. S. Children's Bureau

Itinerant clinics in rural areas or permanent clinics in urban out-patient departments of hospitals afford the usual channel for diagnosis of crippling conditions. As the first point at which the child enters the environment of the agency, the clinic sets the stage for treatment.

Because the child who is in need of medical care in many instances has also social or psychological problems, State agencies are giving increased attention to providing ways and means of individualizing the treatment of each child. To help in reaching this objective for the child and his parents and to discover and

deal with whatever social factors may be important in his medical care, medical social workers have been included in the clinic team. The practice of several State agencies points the way to an effective utilization of medical social services in this phase of a crippled children's program.

Medical social workers in these States interview patients and parents after the orthopedist's examination. The primary purposes of the interview are (1) to "sift" problems of attitude or environment, and (2) to take the initial steps in helping the patients or parents to overcome these problems if any exist. The interview becomes part of the diagnostic process of individualized treatment and may be thought of as a preventive social service.

Clinic Organization

The States which utilize medical social services in this manner had first to solve certain problems of organization. The first was the size of the clinics. When the State programs were begun clinics for 75 to 150 children were held in order that as many children as possible might be examined. The large proportion of new cases resulted in hurry and pressure to "run each child through," with little opportunity for discussion or consideration of the particular problems of the child. The tendency at present is toward holding smaller, more frequent clinics, with 20 to 50 children attending, as experience has indicated that greater long-term economy and improved quality of care result. Too, a larger number of children are return patients, requiring less time for examination. Under these circumstances there is time for the orthopedist to discuss with the parents the implications of his recommendations, a procedure which is not only of obvious advantage in itself, but which is a necessary foundation for the medical social services that follow.

Another question was that of parents' attendance at clinics. In the past when large numbers of children were being garnered from various communities for examination, the parents were left behind in many instances for lack of transportation. The value of their attendance, both to discuss the situation with the orthopedist and to share in the plans made for the child, likewise has been demonstrated, so that increasing emphasis is being placed on arrangements for the parents to accompany the child.

Other matters of importance in the clinic are order, space, and timing. Making the orthopedist's recommendations available to the medical social worker prior to her interview with patients or parents without the necessity for her to be present at the examination is one of the early matters of organization which has been solved. A stenographer may take the doctor's notes directly on the typewriter and send the record out from the examining room at once, or the recommendations may be taken in longhand so that they are immediately available to the medical social worker.

The imperative need for privacy in interviewing has also been demonstrated sufficiently well for plans to be made to provide a separate interview room in the hospital, school house, court house, or church. The rapid and concentrated application of case-work skills necessary in successful interviews has been furthered by shutting out from the patient's and worker's consciousness the distractions of the clinic. This improvement, also, obviously had to be made before the medical social worker could do her best work.

In well-organized clinics the parents accompany the children; they have had opportunity to discuss the recommendations with the orthopedist; his recommendations are available to the medical social worker immediately after the examination is made; and she has privacy for interviewing the parents or patients. The parent, or the patient if he is an older child, is usually shown from the dressing room to the interviewing room or cubicle by a volunteer who carries the record on which the recommendations have been written.

Social Problems Encountered

Parents may be fatigued from a long wait when they come to the medical social worker. If it is their first visit to a clinic they bear the strain of being in an unnatural setting and

are likely to be confused by the various processes to which the child has been subjected. In their minds may be a welter of conflicting emotions. In a few instances when parents reach the social worker it will be found that they have a complete understanding of the doctor's recommendations and their own plans may be already formulated for carrying out the many details necessitated by the treatment. However, less mastery of the situation is encountered with the majority of parents. Ignorance, language handicap, lack of acquaintance with medical terms, inadequate time fully to digest the discussion, may have left the parents with incomplete understanding or actually with misunderstanding of what the doctor has said. Whatever their intellectual capacity, apprehension may be clouded by fear, shock, disbelief, uncertainty, disappointment, relief, or conflict with religious beliefs. Familiar to all of us is the experience of failing to listen to or understand the remainder of a discussion if some word, or some emotion called up by a sentence, carries the mind away, while to outward appearance the response is normally receptive. This seems to be especially true in relation to medical experiences. Hence, in many instances, some further interpretation of medical recommendations in the light of the patients' or parents' reactions may be necessary.

Frequently necessary also is aid in correlating treatment plans with the practical problems of everyday living. For example, the father of a child may be able to bring him to the hospital if admission can be arranged on a day when he can get away from work; the child may not rebel against treatment if it can be arranged during vacation; the mother may be able to provide adequate aftercare if treatment is arranged after the birth of the baby she is expecting. These are details which may influence the parents' and patients' reactions towards the recommendations. If these can be learned and plans for meeting them initiated at the time of the clinic visit they do not remain to cloud the decision of the parents and create unnecessary obstacles in their minds.

These matters, largely of management, make up the majority of social problems encountered at the clinic. Sprinkled among them, however, are the serious difficulties which, if undiscovered, may thwart the treatment plan or the ultimate goal of the child's adjustment. The mother who is advised to place her child in an institution on the ground that he is feebleminded; the mother who is advised that the half-grown daughter, on whom she has pinned her own desires for self-expression, will never be able to walk; the mother who believes in her own heart that by tying a red string around the child's wrist she can accomplish more than the surgeon and with less inconvenience; the mother who unconsciously wants release from the burden of the child's care and who hears the doctor advise home care instead of hospitalization as she had expected: these are some of the parents whose children may not profit from medical recommendations unless their reactions are discovered and appropriate measures undertaken. To sift such problems is one of the primary values of the interview, and the sifting is one of the processes which requires a specific professional skill.

Technique of the Interview

The rapidity with which the interviews have to be conducted necessitates a telescoping of the usual interviewing processes, which is successful only if the worker is experienced and has well-developed interviewing skills. Her knowledge of possible ramifications of similar diagnoses in varying social settings is a part of her equipment. To survey the probable meaning of the medical situation in the light of fragmentary social data that she is able to obtain; to follow significant clues without the waste of drawing out the individual on issues that are not pertinent; to separate real obstacles of environment from those voiced to cover deeper problems; to sketch in the total from the fragment: these requirements must be met if the "sifting" interview is to be successful.

The ability of the worker to conduct these interviews is predicated upon a good general knowledge of orthopedic conditions and specific knowledge of the condition of the child as stated by the orthopedist; knowledge of the

treatment implications of the child's condition in terms of cost, time, procedures, and prognosis; education and experience in correlating medical and social situations; and a sensitive interviewing technique.

Interviews With Return Patients

In relation to return patients, the interview of the medical social worker has somewhat different purposes. The emphasis may change from service to the parents or patients to team play with the doctor in insuring satisfactory medical progress. It may serve merely to provide continuity of personal interest throughout the treatment process for the patients, or it may afford some opportunity for social treatment.

If the clinic record that accompanies the patient to the worker's room indicates that progress is not satisfactory and if the diagnosis is one in which social conditions are influential in that progress, reexamination of the social situation with emphasis on pertinent points can be made. For example, it may be found that the family situation is such that recommendations prescribing diet, bed rest, or appliances are not being carried out. Attitudes may have grown up, or have been undiscovered previously, which deter the patient's progress. Social treatment may have been begun during the child's hospitalization in which case the child's clinic visits afford opportunity for continued discussions or for maintenance of a relationship necessary to the treatment. For many reasons it is usually desirable for the medical social worker to see the parents of return patients, as well as those of new.

Postclinic Consultations and Conferences

Conferences with local workers which are held after the sessions of an itinerant clinic are thought of in many States as part of the medical social worker's clinic services. These conferences are possibly the most profitable of any form of consultation service.

In rural areas the opportunity serves for utilization of the dramatic interest aroused by the clinic to plan continued services to children. Nurses and welfare workers have reviewed their cases, volunteers have gone out to bring patients and parents in, women's groups may have cooked hot lunches, and in some areas everyone from the minister to the editor of the local newspaper is interested in crippled children at that time. Interpretation of children's needs and joint plans for the services to be given are particularly effective then. The county welfare worker, who has received the orthopedist's recommendations and has seen the child in a semimedical setting, is alert to the discussion of his care. The enthusiasm and fresh memory of all the personnel can be utilized at this point.

No less important than the community's heightened interest in the program at the time of the clinic are the interest and availability of the State and local staff for joint discussions of the children who have been seen. The postclinic conferences observed in some States seem to afford especially valuable opportunity for mutual exchange of findings and correlation of the various possible medical and social values to the child.

The orthopedist who thought that the parent was dissatisfied with the treatment of a spastic child may hear from the medical social worker that the mother is in reality trying to place the child elsewhere to avoid giving him further care. He may learn from the local welfare worker that the frightened and withdrawn child is mistreated at home.

The vocational-rehabilitation agent may learn from the orthopedist that the girl who wants training as a beautician will never be able to perform work that requires long hours on her feet and from the local nurse that the girl is needed at home temporarily to care for an ill mother.

Each member of the participating staff may profit from the knowledge of the others in making his own plans, and the plan of each tends to become a coordinated part of the whole.

Summer Courses in Maternity Nursing

University of California An institute on maternal and child hygiene will be offered to registered graduate nurses during the summer session at the University of California in Berkeley, July 1–20, 1940. It has been planned for 3 weeks only so that nurses employed by health departments may attend without causing inconvenience to their departments. Classes will be held from 9 a. m. to 1 p. m. daily.

The Department of Hygiene of the University of California through the Division of Nursing Education will direct the activities. Louise Zetzsche, supervisor of the Maternity Service of the Denver (Colo.) Visiting Nurse Association, will be the guest instructor. Dr. Ellen S. Stadtmuller, Chief of the Bureau of Child Hygiene, State Department of Public Health of California, and members of her staff will lecture on medical problems in maternal and infant hygiene.

Three units of credit will be granted for attendance and satisfactory completion of work. The fee for the institute is $17.50.

Catholic University of America A course on public-health nursing in maternal and child hygiene is offered at the Catholic University of America, Washington, D. C., as a regular part of the summer session, June 28–August 10. The instructor for the 1940 season is Elizabeth R. Ferguson, consultant in maternity and child hygiene, Maryland State Department of Health.

University of Minnesota A course in maternal and child hygiene, with Dr. Maysil Williams of North Dakota as instructor, is offered by the University of Minnesota as a part of its regular summer session.

Institute for Graduate and Postgraduate Dentistry

The dedication of the new W. K. Kellogg Foundation Institute for Graduate and Postgraduate Dentistry at the School of Dentistry, University of Michigan, took place April 3, 1940.

Among the courses offered, which are open to practicing dentists in Michigan and elsewhere, are 2-week courses, also courses given 1 day each week.

Journal of Michigan State Dental Society, March 1940, p. 81.

State and Territorial Health Officers

On May 9, 1940, the State and Territorial Health Officers met with the Public Health Service and on the morning of May 10, with the Children's Bureau. The conference discussed administrative problems of the maternal and child-health and crippled children's programs, including problems relating to the merit systems put into effect following the 1939 amendments to the Social Security Act.

On the afternoon of May 10 they were invited to attend the opening session of the American Scientific Congress.

Recent Tuberculosis Studies

Tuberculosis among young women The problem of tuberculosis among young women—the seriousness of which is indicated by the fact that the death rate from tuberculosis for young women between 15 and 25 is higher than for men of the same age or for older women—is discussed in two recent publications.

Tuberculosis Among Young Women, by Edna E. Nicholson (Social Research Series, No. 7, National Tuberculosis Association, 50 West Fiftieth St., New York, 1938, 67 pp.), is a combined and revised edition of two studies of tuberculosis mortality among young women made by Miss Nicholson several years ago in New York and Detroit and published as Social

Research Series, Nos. 1 and 4. The author concludes that although other factors may have some bearing, "the psychic and the physical changes of adolescence and early adult life cause young women to be unusually susceptible to tuberculosis and constitute the fundamental reasons for their high mortality rates."

Young married women with tuberculosis

The special obstacles facing young married women who have been discharged from tuberculosis sanatoria are set forth in an article by Holland Hudson, Young Married Women Patients (*Bulletin of the National Tuberculosis Association*, Vol. 25, No. 11, November 1939, pp. 169–170, 174–175). The author believes that some way must be found to teach these patients how to meet the demands of homemaking in such a way as to conserve their strength and prevent reactivation of the disease.

Protection of children exposed to tuberculosis in the home

In the *Milbank Memorial Fund Quarterly* for January 1940 (Vol. 18, No. 1), appears a paper by Jean Downes, Salient Points of Attack Against Tuberculosis, which gives data on the age incidence of active tuberculosis in Cattaraugus County, N. Y., during the period 1923–33, and the age curve of mortality from tuberculosis in the original registration area of the United States. In the Cattaraugus study deaths from tuberculosis were found to constitute a high proportion of the deaths from all causes among the offspring of a tuberculous parent. In view of the relatively great hazard of tuberculosis among family contacts—from 10 to 15 times as great as in the general population—it is recommended that individuals who have been exposed to infectious tuberculosis in the family should have the benefit of public-health supervision during infancy, during late adolescence, and through early adult life.

Age incidence in tuberculosis mortality

Wade Hampton Frost, in The Age Selection of Mortality From Tuberculosis in Successive Decades (*American Journal of Hygiene*, November 1939; reprinted in *Milbank Memorial Fund Quarterly*, January 1940) interprets the curve of mortality from tuberculosis at successive ages as indicating that the present day "peak" of mortality in late life does not represent postponement of maximum risk to a later period, but rather that the present high rates in old age are the residuals of higher rates in earlier life, since the frequency and extent of exposure to infection have decreased progressively decade by decade.

BOOK NOTES

WE, THE PARENTS, by Sidonie Matsner Gruenberg. Harper & Bros., New York, 1939. 269 pp. $2.50.

Mrs. Gruenberg discusses in her most recent book many of the questions that confront the modern parent. The book carries the reader through the periods of infancy, childhood, and adolescence and closes with a discussion of early adult life.

The merits of a regular schedule for an infant are mentioned, but emphasis is placed also on the need for a common-sense approach and an appreciation of the underlying needs of each infant. Training the infant for bowel and bladder control is discussed in the light of newer knowledge of the maturation rate of infants. Much emphasis is placed on the atmosphere of the home and the relationship between the mother and father and between the parents and children. Problems of discipline and authority are directly related to the home environment. Punishment is discussed, and an understanding approach to children is presented by which many punishments may be avoided.

Children differ very much from one another, and parents need to make an effort to understand each child and appreciate his needs in the light of his capacities. Too much stress must not be placed on any single measure of a child's capacities, such as the intelligence quotient. It is difficult for many parents to reconcile the concept of freedom and tolerance for the individuality of each child with the idea of instilling a respect for the "cardinal virtues." Mrs. Gruenberg believes that parents have an obligation to foster characteristics such as honor, loyalty, and truthfulness in their children. She suggests:

> We have to let the erring child know that we are aware of what he has done but without making him feel that he has been damned for

life. The child needs sympathy that assures him, not so much of forgiveness, as of understanding. It is not a question of condoning and overlooking errors but of helping the child use them for his own growth. The parent's tact shows itself in overlooking some blunders, treating others casually and lightly, and using still others as stepping stones for the child's own advance in self-understanding and self-control. We have to make the child feel, not tell him, that our efforts come from our affection and enduring confidence, not from our resentments or annoyance.

A chapter on sex education is included in which are discussed curiosity, ways of giving information, language, parents' anxieties about sex matters, and sex interest in the child and in the adolescent. Other sections in this chapter deal with homosexuality, crushes, parental jealousies, and chastity and ideals.

The use of money is discussed in a separate chapter. Reading, radio, and movies are considered at some length. One chapter is devoted to the relation of school and home.

In the last two chapters, Toward Adulthood and Parents Are People, many difficult parental problems are discussed.

We, the Parents, has been given the award of *Parents' Magazine* as "the book of the year for parents."

D. V. W.

WHY BABIES? by Rachel Violette Campbell. Macmillan Co., New York, 1939. 163 pp. $2.

Rachel Campbell has had four babies. She has written a book to tell how much she has enjoyed these babies. For herself she prefers babies, home, and domesticity to the newspaper work in which she was engaged formerly.

In her book she discusses many aspects of the problem of having babies. She begins with the time before the first baby comes and gives suggestions, both material and psychologic, concerning the preparation of the mother and also the father for the coming child. The period of early infancy is dealt with in detail, and many suggestions are offered concerning the handling of such matters as diapers, baths, food, and eating habits.

POLIOMYELITIS IN THE CITY OF MELBOURNE, 1937–1938, by Hilda W. Bull, Dr. P. H. Health Committee of Melbourne City Council, Australia, 1939. 56 pp.

The most severe epidemic of poliomyelitis that has ever occurred in the State of Victoria, Australia, began in July 1937 and reached its peak by the end of August. This survey, made under the direction of the Medical Officer of Health of the City of Melbourne, covers the epidemic in Melbourne only. Between August 1937 and March 1938 there were 174 reported cases of poliomyelitis in Melbourne, a city with a population of 92,000.

The greatest number of cases were recorded in August and September, which are late winter months in Australia. This is probably the most remarkable feature of the epidemic, since winter outbreaks of poliomyelitis in epidemic form are very rare.

The epidemic began in a suburb of Melbourne and spread with great rapidity. The most obvious focus was the out-patient department of the Children's Hospital, where the child who developed the first case in Melbourne had been in close contact with 10 children, several of whom developed abortive cases.

Eighty-two percent of the reported cases involved children under 10 years of age and 42 percent, under 5 years. Fifty-six percent of the patients were males and 44 percent, females. There were 12 deaths. There was a high incidence of bulbopontine and upper-spinal paralysis. Multiple infection in families was higher than usual, occurring in 8.6 percent of the families.

Only cases developing paralysis were reported officially, but 199 abortive cases are discussed.

Various cases are described, both paralytic and abortive, in order to bring out the point that human contact is the important mode of spread of the disease.

S. S. D.

WAYS TO COMMUNITY HEALTH EDUCATION, by Ira V. Hiscock et al. Commonwealth Fund, New York, 1939. 306 pp. $3.

Information, suggestions, and sources of materials to meet the recognized need for special preparation in the art and science of public-health education are offered in this volume. The book is concerned primarily with community-wide efforts to build up the understanding of the whole population and to stimulate individuals and groups of citizens to specific action for the promotion of their own and their community's health.

The authors state that community health education has varied aspects, including health teaching of children in schools, improvement of the health habits and attitudes of the average citizen, and even the professional training of physicians, dentists, and nurses so far as these are concerned with the public health. In order that the program may reach its greatest effectiveness all related agencies, official, nonofficial, and professional, must cooperate.

Following the discussion of the various phases of a community service for health education, there is a description of the organization and operation of a program in a middle-sized city. Numerous references are given at the end of each of the 14 chapters, and in the appendixes are given sources of material for public-health education and suggestions in regard to printing.

C. E. H.

EMPLOYMENT PROBLEMS OF MINORS

Guidance of Youth Through NYA Projects in North Carolina

By Mary G. Shotwell

Director, Division of Employment, NYA for North Carolina

THE work program of the National Youth Administration is essentially a form of guidance through work experience. This work experience helps young people applying for jobs to meet the objection of many employers to hiring young workers who have had no previous experience.

The selection of the youth for assignment to a work project of the NYA is of great importance. In planning for the assignment to work projects certain guidance principles are considered:

1. Is the work suitable to his interests and abilities?
2. Does it provide opportunity for new experience and training?
3. Does it provide possibilities beyond the present job?
4. Does the youth realize the need of developing good work habits?
5. Does the present work project aid him in developing these habits?

Every possible aid is given to help an individual orient himself. The work on the project offers an opportunity for new experiences and self-discovery.

During the fiscal year 1939–40 an average of 10,000 boys and girls have worked on the NYA program in North Carolina. There are two types of projects: Local projects on which youths work during the day and return to their homes at night; and the resident centers where they live and work on the project.

On the local projects the type of work has covered training in homemaking, domestic service, waitress work, weaving, and handicraft for the girls and the making of furniture and pottery, construction of buildings, landscaping, and agriculture for the boys. There is a sponsor for each project who furnishes a building and materials for the work. Public agencies, such as boards of county commissioners, public schools, boards of health, and departments of public welfare, are sponsors for the projects.

The work done on the sponsor's time does not belong to the youth, and the products can be used only by the sponsor. In many instances the young people are so interested in what they are doing that they return to the project after working hours in order to make something for themselves. Recently on one of the projects a boy cut a large cedar tree and had it sawed into lumber for use in making furniture for his home. He made a cedar chest and a combination desk and bookshelf and was happy in the fact that he had made such beautiful pieces of furniture.

There are 17 resident training centers distributed throughout the State, 5 of which are for Negro boys and girls, 1 for Indians, and 11 for white youths. The centers not only develop skills but teach the young people to work together and to live cooperatively. The youths receive their room and board and $12 a month, which defrays personal expenses.

Each center is sponsored by some public agency and is attempting to do a special type of work:

Bricks Training Center for Negro boys and girls is located in an agricultural community, and the boys are

trained in general farm work and the care of livestock. They cultivate about 100 acres of farm land for the sponsor. The occupational experience offered to the girls is in homemaking, including sewing, cooking, gardening, and canning.

At the Hickory Grove Center white boys are constructing a vocational-school building and receive training in carpentry and bricklaying. Training in auto mechanics is also offered, and many boys are taking advantage of this work-experience opportunity.

The Sardis Resident Center for white girls offers training in dress designing, sewing, budgeting, marketing, cooking, and salesmanship. A health course which covers general instruction in home, bedside, and invalid nursing is also given. The salesmanship class, in addition to teaching the girls the values of buying and selling, includes a comprehensive course in consumers' education and the budgeting of income to take care of personal needs. Improvement in personality and poise is encouraged and emphasized.

The trainees in the business course at Greensboro Resident Center are required to take dictation and to typewrite at moderate speed. The purpose of this center is to give work experience in order to meet the requirements that many employers make regarding experience. The youths are placed in many of the public offices in the city of Greensboro and get actual work experience. Through the facilities of the Woman's College of the University of North Carolina the girls receive instruction in the type of work in which they are engaged. Other courses in the field of home economics and recreation are open to them. Several girls have received excellent positions in private employment as a result of their training at this center.

All the centers have student government, and the rules and regulations governing the centers are made by the judicial board of the student council and approved by the supervisor. They hold meetings once a week and adjust any problems which may arise. The young people are assuming responsibility and developing in leadership.

In order to measure what progress an individual is making on a project the foreman who works directly with the youth makes frequent reports on his work. If the training and work experience of the youth are satisfactory he is required to visit the State Employment Service so that he may be considered for employment when an opening occurs. If the youth does not make satisfactory progress, he is transferred to another project in line with his interests and abilities.

The importance of doing the job right, being on time, and working well with other people are valuable lessons for young people to learn. They develop through work experience good work habits and a sense of responsibility.

Minimum-Wage Rates for Sugar-Beet Workers Announced

The Sugar Division of the United States Department of Agriculture has announced a continuation of the 1939 basic minimum rates to be paid laborers in the production, cultivation, or harvesting of the 1940 sugar-beet crop by producers in the continental sugar-beet area who make application for payments under the Sugar Act of 1937.

The act requires, as one of the conditions of payments, that all persons employed on a farm in the production, cultivation, or harvesting of sugar beets be paid in full for such work at rates not less than those determined by the Secretary of Agriculture, after investigation and public hearing, to be fair and reasonable.

Hawaii Designated Under Fair Labor Standards Act

On April 12 Hawaii was designated by the Chief of the Children's Bureau, United States Department of Labor, for acceptance of Territorial certificates of age under the Fair Labor Standards Act. The Territorial certificates, provided for under the recently enacted child-labor law of Hawaii, are being made available through the cooperation of the Territorial Department of Labor and Industrial Relations. Charles Savage is the director of the department in Hawaii.

The designation of Hawaii marks the first extension of the age-certificate provisions of the Fair Labor Standards Act to Territorial jurisdictions and brings the total number of designations to 44.

Federal Certificates of Age in Texas

Since April 15 Federal certificates of age for minors have been issued in Texas to employers engaged in the production of goods which are shipped in interstate or foreign commerce. These certificates, showing the age of the minor, will protect employers from unintentional violation of the child-labor provisions of the Fair Labor Standards Act of 1938. Texas had been operating under a temporary child-labor regulation, which provides that in States where certificates of age are not available birth certificates or baptismal records will be accepted as certificates.

The Children's Bureau has opened a Texas office at 404 Old Post Office Building, Austin, where Federal certificates are issued. The cooperation of State and local officials has been obtained to make these certificates of age available throughout the State.

BOOK NOTES

National Youth Administration studies Occupational studies recently received from State offices of the National Youth Administration include the following:

Livestock Industry in Wyoming, by C. W. Skinner. National Youth Administration for Wyoming, 600 East Twenty-fifth St., Cheyenne, 1939. 115 pp.

Structural Steel Workers (revised). National Youth Administration of Illinois, Merchandise Mart, Chicago, December 1939. 39 pp.

The Canning Industry in Ohio, by Mary J. Drucker. Study No. 4, National Youth Administration in Ohio, May 1939. 77 pp.

The Textile Industry in South Carolina. National Youth Administration for South Carolina, November 1939. 103 pp. plus appendix.

Women's Bureau bulletins Recent bulletins issued by the Women's Bureau of the United States Department of Labor, Washington, D. C., include:

Job Histories of Women Workers at the Summer Schools 1931–34 and 1938 (Bulletin No. 174, 1939; 25 pp.). This presents the industrial background and experience of some 700 women who attended the various summer schools for workers in 1931–34 and in 1938.

Hours and Earnings in Certain Men's-Wear Industries (Bulletin No. 163–6, 1939; 22 pp.). The industries covered are caps and cloth hats, neckwear, work and knit gloves, and handkerchiefs.

Standards for Employment of Women in Industry (Bulletin No. 173, 1939; 8 pp.).

WELFARE OF FAMILIES OF SUGAR-BEET LABORERS; a study of child labor and its relation to family work, income, and living conditions in 1935, by Elizabeth S. Johnson. Children's Bureau Publication No. 247, Washington, 1939. 100 pp.

The gravity of the problems faced by field workers in the sugar-beet industry is made apparent by the factual findings of this survey, the second conducted by the Children's Bureau of conditions among children in the families of sugar-beet workers. The first study, Child Labor and the Work of Mothers in the Beet Fields of Colorado and Michigan, was made in 1920.

The present study is based on interviews with 946 families of sugar-beet laborers in Michigan, Minnesota, Colorado, Nebraska, Wyoming, and Montana. It covers the fall and winter of 1935, the first year in which labor provisions were included in the production-control contracts under the sugar-beet benefit program authorized by the Jones-Costigan Act.

In the families interviewed, 670 children between 6 and 16 years of age were reported as working in the beet fields. Of these children 280 were known to be under 14 years of age—about 19 percent of all children between 6 and 14 in the families. In 1934, however, prior to the establishment of the 14-year minimum age under the contracts, about 43 percent of the children in this age group had been working, according to the information obtained from the families.

Family earnings for beet labor were found to be very low. The average income from beets for the entire season was $340 per family for 374 families supplying this information. Most of the families obtained a little supplementary work and income, but this amounted to an average of only $51 in the course of the year, exclusive of relief. Support from relief funds was received by 63 percent of the families interviewed.

"Along with meager family incomes and the frequent need for assistance from relief agencies went poor living conditions involving inadequate diet, insufficient clothing, poor housing, and lack of needed medical service for most of the families." Their dwellings were frequently in poor repair and were usually overcrowded.

TREND OF CHILD LABOR, 1937 TO 1939. Reprinted from *Monthly Labor Review*, Vol. 50, No. 1 (January, 1940). Single copies available while the supply lasts from U. S. Children's Bureau, Washington, 1940. 17 pp.

Employment certificates were issued for more than 7,000 children 14 and 15 years of age and more than 75,000 young workers 16 and 17 years of age in the States and cities reporting to the Children's Bureau in 1938. This area comprises almost 60 percent of the total population of the United States.

The decrease from 1937 to 1938 in the number of certificates issued for children under 16 corresponded roughly to the downward trend in nonagricultural employment throughout the country; the fact that this decrease continued during the first half of 1939, contrary to the upward employment trend of that period, is attributed primarily to the effect of the Fair Labor Standards Act of 1938, which drastically restricted employment of children under 16 in industries producing goods for shipment in interstate commerce.

The discussion covers the number of children for whom regular certificates were issued, the number for whom certificates for work during vacation and outside school hours were issued, the sex distribution of the children, their schooling, and the occupations they entered.

In the reprint supplementary material, not included in the original article, is given on the evidence of age required for certificates. This shows that more than 60 percent of the certificates issued were based on the evidence of birth certificates—the most reliable kind of age proof. A concluding section on future developments in the reporting system has also been added.

MIGRATION AND SOCIAL WELFARE; an approach to the problem of the non-settled person in the community, by Philip E. Ryan. Russell Sage Foundation, New York, 1940. 114 pp. 50 cents.

A careful analysis of the sources and causes of migration and of the social effects of inadequate welfare provision for the nonsettled person in the community is made in this brief survey. It outlines the more important community problems that develop in connection with migration and the programs and proposals of interested groups to meet these problems. The main focus of the report, however, is toward a realization that migration is a problem which challenges national attention and which requires a Nation-wide coordinated approach on all levels of government and between governmental and private agencies.

Although the monograph is stated to constitute only an "approach" to the subject under discussion, it outlines the bases on which any final solutions must be grounded. It concludes with the following statement of policy on government planning:

> With the establishment of Federal responsibility for coordinated, long-range planning toward a national policy for migration, an imperative first step will have been taken. To assist in these developments, the focusing of private interest through some such organization as the former Council on Interstate Migration is also necessary. Bringing the public and private agency groups together for joint planning would eventually result in benefit to all concerned—the migrant, the community, and the Nation as a whole.

The study contains a useful topical bibliography on interstate migration.

The author was executive secretary of the Council on Interstate Migration until its dissolution late in 1939, and the study was made on special commission from the Social Work Year Book Department of the Russell Sage Foundation.

Foster-Home Finding in a Florida County

By a Child-Welfare Worker

In rural counties where there have been few child-welfare services a new child-welfare worker must develop her own resources. This means in many instances the raising of funds for general relief and boarding care. One of the most important needs is for foster homes, for either temporary or long-time care of children. In a community where this type of service has not been known an intensive home-finding program may be necessary. The need for boarding-home care must often be interpreted, and the doubts of prospective foster parents concerning the health and behavior of the children who are to be placed by the worker must be allayed.

In the community on which this report is based nothing was known of boarding-home care until 2½ years ago, when the present foster-home program went into effect. A number of methods for foster-home finding have been necessary.

By far the most valuable assistance in finding good foster homes has come from foster mothers themselves. From their understanding of the program and from their experience with the things involved in taking a foster child they are able to judge the possibilities of their friends as foster parents and to refer the agency to people interested.

Any form of publicity concerning the agency's program usually brings foster-home applications. These must be carefully weeded out. Letters received as a result of newspaper publicity are quite likely to close with statements such as, "Let me know when to come for the child," or "Just send him on the bus and let me know when to meet him." In considering the total number of homes accepted the agency finds that this type of publicity has not been particularly valuable so far as the finding of good foster homes is concerned. This is doubtless due in great part to the fact that newspaper articles do not afford opportunity for detailed explanation of standards and requirements.

Good foster homes, on the other hand, have been found as the result of talks before parent-teacher-association meetings, women's clubs, and various church groups. In this type of publicity standards can be set forth in some detail, and prospective foster parents are better able to consider what their home can offer a child and what the child can mean to them.

A few referrals have come from other agencies in the community, such as the district board of social welfare and the juvenile court.

Another source is the personal application of the prospective foster mother. The agency has had several of these. A woman may know a family who has one of the agency's children, but instead of going to that family she comes to the agency to learn about the foster-home program. Or she may have known of a similar program elsewhere. One of the agency's best foster homes is that of foster parents who had had several years' experience in the same work in another State. They moved to Florida, and the foster mother immediately applied to the agency for children to care for.

Most of the people who desire to take children into their homes understand the value of a home study. They realize that by knowing

as much as possible about the home, the agency can place a child there who seems particularly fitted for that home, so that both the child and the foster family derive the greatest benefit. Foster parents gladly accept supervision by the agency and have shown a great deal of cooperation in working out problems affecting the children.

Foster parents have various reasons for taking children into their homes. Probably the most frequent reason is the desire for companionship for their own children. All foster parents so far approved by the agency have one or more children of their own; very few childless couples have made application. Other interests are the love of working with children and the foster parents' desire to see what success they can have in helping a child overcome certain problems. These are usually people who have had a good deal of previous experience with children, and they accept the problems affecting them as a challenge. Then there is the desire for a small child in the home where the children are almost grown. One foster mother is interested in taking two children from the same family, because she and her brother were separated when they were children and she has always regretted it. Another foster mother is interested because for several years she wanted to adopt a small child but was always prevented from doing so by her family and relatives. Now her only child is grown, and she is finding a great deal of satisfaction in offering her home as a foster home.

A few years ago, before the present program was begun, it probably would not have been possible to find a foster home of the right sort for a girl like Marie, who has been something of a problem to the child-welfare worker.

Marie is a 13-year-old girl who has been helped by foster-home care under the supervision of the child-welfare center. Her father died of tuberculosis several years ago. Her mother, who always had many "boy friends," spent her time wandering about the country. Usually Marie and her younger brother were taken along on these trips. They never knew what it meant to have a home of their own.

Finally, from New York, Marie took it upon herself to write former neighbors in Florida asking if she could come to live with them. They agreed, and Marie came to their home. She has relatives in the town, relatives with court and jail records, relatives of whom no one could be very proud. In dealing with some of them the juvenile court found that the home in which Marie lived was one of extremely low economic standards and that Marie was not getting school lunches and was without proper clothing. The child-welfare center was asked to assist with this situation. Upon investigation it was found not only that Marie was not getting enough to eat and not having proper clothing, but that she was living in a home where there was an adult with active tuberculosis. Plans were then made to place her in a boarding home. The mother, who came to Florida when notified of this by relatives, interfered as she had done on previous occasions when an agency tried to take a hand. She wanted to take Marie back to New York. This time the juvenile court stepped in, took custody, and Marie was placed in a foster home under the supervision of the child-welfare center.

At first Marie ate all the food she could get her hands on and made herself sick. She was amazed that all the food in the refrigerator did not have to be eaten at one time but that there would be enough left for another meal or another day. She was brought to the center to try on shoes. She tried on a pair which were obviously too small. Nothing could make her take those shoes off to try another pair, so great was her fear that none would fit and thus she would not be given shoes. The shoes that were finally selected were carefully cherished, removed on her return from school, polished, and wrapped in tissue paper.

When school opened it was found that Marie was having a struggle with arithmetic. It was feared that she would object to being placed in a lower grade for this subject, but the foster mother has been able to make her see the advisability of such a plan. She is now working hard at fifth-grade arithmetic and is doing seventh-grade work in her other subjects. She has made a good adjustment at school as well as in the foster home.

The foster family and their relatives are extremely interested in Marie. They have been able to give her a feeling of security and of "belonging" that she had never known. Her worry now is for her younger brother who lives with his grandfather and who is not having so happy a life as she is.

Mentally Defective Children

Proceedings and Addresses of the Sixty–Third Annual Meeting of the American Association on Mental Deficiency, held in Chicago in May 1939, contains several papers of special interest to persons dealing with the problems of mentally defective children (*Journal of Psycho-Asthenics* for 1939, Vol. 44, Nos. 1 and 2).

A Comparative Study of Institutionalized and Noninstitutionalized Subnormal Girls, by Dr. Kinder and Dr. Abel, discusses the differences in social attitudes of two groups of 10 girls each, one from the Trade Extension Classes of the Manhattan Industrial High School for the Women's Garment Trades and one composed of girls who had been inmates of Letchworth Village for 6 or more years. All the girls came originally from a metropolitan New York environment, were between 17 and 19 years of age, and had intelligence quotients between 50 and 65.

Social Status of Foster Families Engaged in Community Care and Training of Mentally Deficient Children, by Myra W. Kuenzel, psychologist for the Children's Home of Cincinnati, describes 42 foster homes in which 82 mentally deficient children were boarded. Slightly more than half of the 42 homes were in the city; all but one of the 10 homes used for colored children were in the city. The average chronological age of the children was 11.8 years, although children from 2 to 20 years of age were included. Children of all mental levels, even bed cases, were cared for.

Present Needs in the Care of Mental Defectives in New York City, by Edward J. Humphreys, M. D., and Marion McBee, is a report of the data submitted to a subcommittee of the New York City Committee on Mental Hygiene and the Mental Hygiene Section of the Welfare Council on 436 children scheduled for commitment to institutions for the feeble-minded; 532 children with intelligence quotients under 90, known to the Children's Division of the New York City Department of Welfare; 11,800 children in the ungraded classes under the New York City Board of Education; 385 children with intelligience quotients of less than 80 who came to the attention of the mental-hygiene clinic of the Court of Domestic Relations; and information from the State schools for defectives and from correctional institutions.

Attention is called to the great need for increased provision for clinical service, as well as for expanded educational and training programs, and for closer integration of psychiatric, psychological, social-work, and educational programs of State institutions and community agencies.

Among other papers included in the proceedings are 4–H Clubs for Mental Defectives, by Dorothy A. Pollock, a description of the use and value of 4–H Club work for feeble-minded girls under the care of the State School at Newark, N. Y.; and The Conditioned–Habit Treatment of Nocturnal Enuretics, by Dr. Joseph R. Deacon, a description of the method used in preventing enuresis at the Training School at Vineland, N. J., which may be helpful to persons dealing with this same problem among normal as well as subnormal children.

M. R. C.

Teaching the New York World's Fair of 1940

For the purpose of bringing into sharp and definite focus the exhibits of art and modern architecture, child welfare, youth activities, the functions of government, and the application of science to industry, the New York World's Fair is issuing a series of six leaflets: A general introduction; science at the Fair; exhibits for the elementary school child; social studies at the Fair; art at the Fair; and food, decoration, and new products.

Teachers and school administrators may obtain copies of these leaflets by writing to the Department of Public Education, New York World's Fair.

BOOK NOTES

JUSTICE AND THE CHILD IN NEW JERSEY. Report of the New Jersey Juvenile Delinquency Commission, Trenton, November 1939. 262 pp.

In this, its final report, the New Jersey Juvenile Delinquency Commission traces the development of New Jersey's basic policy in dealing with delinquency problems and evaluates that policy. It measures, so far as delinquency problems are susceptible to measurement, the extent, nature, and causes of delinquency and analyzes the current operation of the instruments on which the State relies to carry out its basic policy, appraising the strength and weakness of these instrumentalities.

Through the findings of this research the Commission reached certain general conclusions that served as a basis for a series of recommendations relating to: The establishment of a State children's commission to coordinate the operations of certain State departments as they relate to the problems of young people and as they cooperate with local agencies concerned with delinquency control; the establishment of county or municipal children's bureaus; the establishment of a State child-study institute; constitutional sanction for progressive methods of handling juvenile delinquency; the care of offenders 16 to 20 years of age; modifications of juvenile-court procedure; adjustments of the education act; and improvement of the probation and parole services and system.

The body of the report includes historical discussion of the differentiation between the treatment of juvenile and of adult offenders in the United States generally and particularly in New Jersey; case histories and statistical data regarding delinquency in New Jersey; and discussions of the causes of delinquency and of the work of the school, the police, the juvenile court, probation and parole services, and institutions, as well as community experiments in preventing and controlling delinquency.

In the appendixes will be found a statement of the administrative and enabling legislation affecting the Juvenile Delinquency Commission, statistical data derived from the records of juvenile courts and police departments and from a survey of institutional inmates, and a selected bibliography.

FROM BUILDING TO NEIGHBORHOOD—A MANUAL ON THE DECENTRALIZATION OF GROUP WORK, by Abel J. Gregg and Charlotte Himber. Association Press, 347 Madison Avenue, New York, 1938. 60 pp. 50 cents.

During recent years some Young Men's Christian Associations have decentralized their activities and club programs for boys in neighborhoods or communities rather than centering their boys' work in one building. This pamphlet is the result of a study by the Boys' Work Department of the National Council of the Y. M. C. A. and presents current practices of local associations in decentralizing boys' work programs.

Abel Gregg and Mrs. Charlotte Himber discuss briefly such pertinent points as the philosophy of decentralized work, policies as they relate to the central board, committees, group leadership and supervision, membership, financing, and interclub councils.

Material is presented from reports by local secretaries on the methods used to develop neighborhood understanding and support, especially as they relate to parents and churches. There are, also, valuable implications in this manual for the field of group work and its relation to the prevention of delinquency. Emphasis is laid on natural and close environmental factors, especially the family, the neighborhood play group, and the public school, as channels of influence in the boy's group experience. The decentralized program allows greater flexibility in approach to the actual needs and interests of boys as seen by them, their parents, and the communities in which they live.

THE NEGRO IMMIGRANT; his background, characteristics, and social adjustment, 1899-1937, by Ira De A. Reid, Ph.D. Columbia University Press, New York. 1939. 261 pp. $3.50.

Although the present foreign-born Negro population in the United States numbers approximately 100,000 persons, the modern aspects of Negro immigration have received only passing attention in immigation literature, and "statistical data on the Negro foreign-born and immigrant populations are scattered, diverse, and from the viewpoint of validity almost nonexistent," points out Dr. Reid, who spent 10 years in developing a coherent body of knowledge of the subject as the basis for this volume.

The bulk of Negro immigration is from the islands of the West Indies, with males of working age predominating. For the most part the men become industrial workers and the women, domestic servants. Since 1924 the percentage of persons under 16 years of age admitted has steadily mounted, forming from 15 to 29 percent of all Negro immigrants admitted annually between 1926 and 1932. Practically all Negroes admitted during recent years are literate and speak English although often with a distinctly foreign accent.

As often happens among children of foreign-born parents, the child of foreign-born Negroes finds difficulty in adjusting family traditions of behavior and culture to his new environment—"his language is a fascinating mixture of 'rather' and 'okie-doke.' ". In addition he has the consciousness of being a Negro.

PRINCIPLES OF CHILD CARE IN INSTITUTIONS; a handbook for staff study and discussion, edited by Esther McClain and Jessie Charters. Ohio Committee on Children's Institutions, Columbus, 1939. 297 pp.

This handbook was prepared by the Ohio Committee on Children's Institutions in cooperation with the Division of Public Assistance of the State Department of Public Welfare for study and discussion by institution staffs. It fills a long-felt need as a basis for in-service training of staff members.

It is composed of 30 chapters contributed by persons of long experience in children's institutions and related agencies. Each chapter is followed by questions and lesson assignments which may be prepared by individual members of the staff. Not only are the particular problems connected with the institution and its responsibility to the child under its care discussed, but the return of the child to his family and placement in foster homes have also received attention.

Special mention should be made of the chapters dealing with the child and esthetic experience, money experience for children, and individualizing a child.

A brief list of useful books and pamphlets for reference reading by staff members is included.

HANDBOOK OF AMERICAN INSTITUTIONS FOR DELINQUENT JUVENILES. First edition. Volume 2, Kentucky—Tennessee, 1940. Osborne Association, 114 East Thirtieth Street, New York, 1940. 293 pp.

Volume 2 of the Handbook of American Institutions for Delinquent Juveniles is now available, covering the Kentucky Houses of Reform, Greendale; the Louisville and Jefferson County Children's Home (Ormsby Village), Anchorage; the State Training and Agricultural School for Boys, Nashville; the State Training and Agricultural School for Colored Boys, Pikeville; the Vocational School for Girls, Tullahoma; and the Tennessee Vocational School for Colored Girls, Nashville. There is a general introduction, and each of the six institutions is described in detail in a separate chapter.

THE SOCIOLOGY OF CHILDHOOD, by Francis J. Brown. Prentice-Hall, New York. 1939. 498 pp. $2.25.

Although written primarily as a textbook for courses in educational sociology this book has significance, the author believes, for parents, social and religious workers, and all others interested in the wholesome social adjustment of childhood to the complex environment of modern life. Believing that there is an increasing necessity for the better understanding of the social forces and social processes that to a large extent determine the behavior, attitudes, and ideals of the normal individual, the author has limited his field to that of the normal child.

The major portion of the book is devoted to an analysis of the social processes and how they affect the life of the child. The specific situations presented include the family, the play group, the school, noncommercial and commercial recreation, the State, and the church.

MEETING THE NEEDS OF THE MENTALLY RETARDED. Bulletin No. 420, Pennsylvania Department of Public Instruction, Harrisburg, Pa. 1939.

This bulletin was prepared by the staff of the Division of Special Education and published by the Pennsylvania Department of Public Instruction. In addition to detailed information about the procedure in establishing classes for the mentally retarded, standards for such classes are discussed, together with the organization and methods for their conduct.

A comprehensive bibliography relating to mentally retarded persons is given in the appendix.

TRENDS IN CRIME TREATMENT; 1939 Yearbook, National Probation Association, edited by Marjorie Bell. National Probation Association, 50 West Fiftieth Street, New York, 1939. 372 pp.

Described in the foreword as a symposium of progressive thought and practice toward solution of the problem of crime and its younger brother, delinquency, this yearbook of the National Probation Association includes primarily papers given at the conference held in Buffalo, June 16–20, 1939, grouped under the following headings: Checking Early Symptoms of Crime; Changing Delinquent Attitudes; Detention Techniques; the Juvenile Court in Transition; Probation Statistics; Probation Administration; Probation and Parole Progress; Crime and the Public; Legal Digest.

The first section deals with community responsibility for preventing the development of delinquency and includes a group of papers in which are discussed the role of the police, the private agency, and the school in crime prevention, together with a paper on adequate care for defective delinquents.

In the section, Changing Delinquent Attitudes, Harry Manuel Shulman of New York discusses individual treatment of the delinquent within group activity, placing special emphasis on its application to the field of probation.

The papers on the subject of detention techniques include a description of the use of boarding homes for detention in Erie County, N. Y., by Marjorie Lenz, of Buffalo, and a description of the clinical work at the detention home in Allegheny County, Pa., by John Chornyak, M. D., of Pittsburgh.

Wider Jurisdiction for the Juvenile Courts, by Judge Atwell Westwick, of Santa Barbara, Calif., deals with questions pertaining to age jurisdiction, domestic-relations courts, and continuity of jurisdiction. The Future of the Juvenile Court as a Case-Work Agency, by Alice Scott Nutt, of the Children's Bureau, is also included.

EVENTS OF CURRENT INTEREST

CONFERENCE CALENDAR

May 20–23	Boys' Clubs of America. Thirty-fourth annual meeting, Boston. Permanent headquarters: 381 Fourth Ave., New York.
May 20–25	General Federation of Women's Clubs. Council meeting, Milwaukee, Wis.
May 24–29	National Probation Association. Annual conference, Grand Rapids, Mich.
May 26–June 1	National Conference of Social Work. Sixty-seventh annual session, Grand Rapids, Mich.
May 26–June 1	American Library Association. Sixty-second annual conference, Cincinnati, Ohio.
June 3–6	National Tuberculosis Association. Thirty-sixth annual meeting, Cleveland, Ohio.
June 7	American Heart Association. Sixteenth scientific meeting, New York. Permanent headquarters: 50 West Fiftieth St., New York.
June 10–14	American Medical Association. Ninety-first annual session, New York. Permanent headquarters: 535 North Dearborn St., Chicago.
June 17–19	American Gynecological Society. Seigniory Club, Montebello, Quebec, Canada. Secretary: Richard W. TeLinde, 11 East Chase Street, Baltimore, Md.
June 23–27	American Home Economics Association. Thirty-third annual meeting, Cleveland, Ohio. Permanent headquarters: Mills Bldg., Washington.
June 30–July 4	National Education Association. Seventy-eighth annual convention, Milwaukee, Wis. Information: National Education Association, 1201 Sixteenth Street NW., Washington.
Aug. 12–16	National Medical Association. Forty-sixth annual convention, Houston, Tex. General secretary: John T. Givens, M. D., 1108 Church St., Norfolk, Va.
Sept. 2–5	American Association for Applied Psychology. Fourth annual meeting, Pennsylvania State College, State College, Pa. (Section on clinical psychology is of special interest to persons working with children.)
Sept. 8–9	American Association of Public Health Dentists. Cleveland, Ohio.
Sept. 9–13	American Dental Association. Eighty-second session, Cleveland. Permanent headquarters: 212 East Superior Street, Chicago.
Sept. 16–20	American Hospital Association. Boston, Mass.

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A. M. A. Symposium on Health Education

What shall we teach? is the theme of a symposium on health problems in education to be held on June 11 at 2 p. m. in the Grand Ballroom of the Hotel Roosevelt, in connection with the annual meeting of the American Medical Association. The symposium is sponsored by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. The speakers will be Dr. Dunn of the United States Bureau of the Census. Dr. Boynton of the University of Minnesota; Dr. Wilson of the Board of Education, Hartford, Conn.; and Dr. Nyswander of the School Health Study Committee, Astoria, N. Y. Dr. I. H. Goldberger of the New York City Board of Education will preside.